Telemedicine Centers USA

Before the

Federal Communications Commission

Washington, D.C. 20554

In the Matter of

Promoting Telehealth for Low Income Consumers **WC Docket No. 18-213**

REPLY COMMENTS TO NOTICE OF INQUIRY

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FCC 18-112

INTRODUCTION

On September 10, 2018, we closed our Comments to the FCC Notice of Inquiry with a Conclusion Statement deferring a response to certain FCC NOI inquiries that we felt best should be made in a REPLY after our consideration of other relevant filed Comments in these proceedings. Further, certain FCC NOI Comment inquiries can only be resolved by the FCC, since several USF supported, funded and related rural health care specific IT programs are still operational and contain some provisions that can be conflated and easily appear to bump up against established FCC policy to maintain the status quo and protect economic interests.

Specifically, we did not respond to the FCC NOI request number 37 under Part 4:

> **4. Partnering with Facilities-Based Eligible Telecommunications Carriers**
>
> 37. We seek comment on the eligibility criteria for broadband service providers to participate in the pilot program. Specifically, we seek comment on requiring broadband service providers participating in the pilot program to be facilities-based eligible telecommunications carriers (ETCs) designated pursuant to section 214 of the Act[1] in order to participate. We believe that this approach would be consistent with the Lifeline program, which also targets benefits toward low-income consumers and limits service provider participation to ETCs.[2] Further, we believe that participants should be facilities-based ETCs given that one of the goals of the pilot is to increase broadband deployment in unserved and underserved areas. We seek comment on these views. Should we instead permit participation in the pilot program by facilities-based broadband service providers that are not ETCs, and if so, why? Are there other criteria we should consider in determining which broadband service providers should be eligible to participate?

When it is obvious that facilities based eligible telecommunications carriers have not dominated or made a meaningful broadband penetration among low income Americans living within the patient home care direct/community care sites market in unserved and underserved rural areas in the US; it is difficult to understand how this sole broadband provider services segment alone can succeed in building out/expanding to serve this hard to reach and sign up, train and support the targeted low income and Veteran population in a robust Connected Care pilot program. Especially when non-facilities-based (or reseller) ETCs have participated in the Lifeline program for more than a decade, and at present, nearly 70 percent of low-income consumers in the Lifeline program are served by reseller ETCs.

[1] 47 U.S.C. § 214(e).

[2] 47 CFR § 54.201(a)(1).

Discussion of our views, and particularly how the Connected Care Pilot can be structured.

It is interesting to note that the largest providers of mobile and broadband footprint offering connectivity services as wireless telecommunications carriers [including resellers] have provided various bandwidth capacities to health care providers to rural and urban populations within and outside of USF pilots for decades and still have not achieved inclusion of substantial penetration of low income and veterans households to the lifesaving benefits of ubiquitous and affordable provider access to timely treatment and consultation. Perhaps it's time to SEE the problem is not just with hardwire and wireless providers, and a hook up with a stranger health care provider where neither KNOW me and can RELATE to me!

This single FCC NOI request for Comment gave me pause, particularly the inquiry asking are there other criteria the FCC should consider with respect to what broadband service provider should be eligible to participate in the pilot? The answer, of course, is complicated and from reading all the filed Comments with the FCC pertaining to this inquiry I hoped someone else would provide the information that has been hiding in plain sight and has been printed in scholarly health care policy treatises, health care industry strategic planning sessions, Congressional and government hearings with respect to the persistent rising Black- White health care disparities, and the CMS warnings of the danger of re-emergence of Apartheid health care if the availability of telemedicine access to more than 40 million+ US persons of color, multiracial, multicultural, multilinguals that remain unserved and underserved, low and no income, and trapped at the last mile.

Three former Black US Surgeon Generals and activist health care policy experts across America have made their life's work raising this matter as the number one issue within the fast emerging Minority-Majority demographic rural and urban communities. Fortunately, I agree with PWC Health Research Institute that "the US health industry is undergoing seismic change generated by a collision of forces, including the shift from volume to value, rising consumerism and the decentralization of care. This shifting terrain is creating uneven opportunities in the New Health Economy and will likely drive players new and established to reconsider their business models". The unserved/underserved low income populations is motivated to disrupt a fractured health system that refuse to transform itself with our help.

When US hospitals and their owned physician work forces can "fail" to be able to support its millions of unserved/underserved rural and urban populations in their claimed marketplace justifying tax exempt status or their special monopoly-like treatment, but is eagerly expanding its brand and focus in foreign countries and elsewhere in the US; the keys to the unserved/underserved marketplace is open to those new health care entrants that SEE, HEAR

and can TALK to their consumers to build trust relationship. The pocketbook of the US self-paying Employers is opening such that today this sector pays for the health care of more than half of the US population [many of which are low wages] and eager to lower health costs and risks of every employee through technology and home/community connectivity innovations. This sector of the old way of doing business in health care is cutting out the health insurer and the hospital/doctor-office centric brick-and-mortar business model for performance value care at home or community setting with a population health emphasis. This disruption changes forever the business as usual relationship between the community and brick-and-mortar provider, and transform the home/community as the center of the care focus.

Summing up the above as far as the FCC Connected Care Pilot initiative criteria that is missing is INCLUSION of Minority-Majority community-facing broadband providers specifically zeroed in on low income and veterans that does not have to own, control or understand the whole, and is therefore more dynamic and responsive to consumers and fertile for innovation. To be successful in gaining subscriber signup penetration and to manage/create measurable health care improvements of patients and residents within the targeted population, the Connected Care Pilot broadband service provider essentially must transform itself into a new type of broadband services integrator/health population business not unlike how CATV systems and over-the-air broadcasters evolved. Except this pilot hastens a transitioning vehicle that is patient-centric and affords patient convenience, respect and documented performance measurements and timely response based upon real time PHI remote EMR capture.

As roughly referenced in our Comments, as a USF pilot, the Connected Care initiative is more like an encrypted 2way interactive Health Channel that could not only allow primary care doctor visits, behavioral health consultations, physical therapy, maternity and infants care, vision and dental exams, remote monitoring connected to a wide array of diagnostic devices in real time, video conferencing for team management and treatment supervision, watching and being educated on health care subjects, including hotlines for access to community resources, make complaints, chat with friends, pharma and access to HIPPA protected medical records. This is a huge gateway business for Broadband service providers to support.

We know first-hand about creating and managing this new type of technology hybrid business because as the US first Black-owned CATV system operator and successfully franchised in three other states for MSO status, our experience and business relationships with certain giant MSOs allowed us to build-out and achieve high performance in low income urban and rural communities. Our broadband subscriber penetrations in a new build was written about in Cablevision Magazine with high praise. We built community trust and gained acceptance of a workforce that were not viewed as strangers. We were able to be positioned into our communities as something important beyond the entertainment, sports

and pricing for our services. We represented *self-help* for achieving inclusion for our people, and the role model that can help us grow more opportunities for others to manage and own CATV systems. This new FCC Pilot will be the breakthrough into the digital divide and the lifeline long sought for underserved populations emerging as the Minority-Majority in the US.

I was delighted to read the Comment from the NCTA describing the involvement several of its CATV owners acting in or planning to become engaged in the broadband connectivity space with health industry players. Our Florida startup Telemedicine Centers USA is a participant with Comcast's successful USF pilot in several of its franchise's that have sizable populations that are low income and veterans, and is ideal for this Connected Care pilot without any interference with Comcast's interest in serving other health industry players. We would be no more than one of Comcast partnering exploratory health industry relationships under its broad broadband umbrella that will pursue a targeted segment of the total US population.

Additionally, Comcast introduced us to Time Warner Cable when we planned to launch our first CATV franchise, and that is when we shared the QUBE technology utilizing 2way capability throughout our coaxial and fiber CATV system. Over the years we were assisted by Charter Communications in the design of a broadband network connecting each HBCU and Native American community to support low income communities surrounding the schools and its health professions training and outreach. Three years ago, Time Warner supported our successful demonstration and proof of performance in Hawaii where we equipped a medical office examining room in Maui for a patient to be examined remotely by a roomful of clinical executives in a conference room on the 15th floor of an insurer's downtown Waikiki building in real time! We included this capability in Hawaii's State Plan to CMS.

In each of these instances we were considered a broadband authorized reseller for our clients where the broadband provider had a specific list of deliverables for us, and we had deliverables as a reseller to them and our clients to perform telecommunications applications and use of connected digital diagnostic assessment and in some instances monitored biosensor and continuously streaming captured PHI from patients in SNFs, clinics, schools, and in homes. This is why a reseller with specialized expertise in health care technology and delivery can be extremely valuable in not just focusing on the IT aspects, but in making sure everything is working, that the home patient/caregiver is trained [or provisions made for use of the home installed capability when needed], responding to service and maintenance needs, and the same for the remote destination health providers.

One other thing that ought to be an important criterion: the vision that the *driver* for the Connected Care Pilot ought to be the home patient subscriber, not the broadband supplier nor the health care providers. We have to enlist family and community based resources; develop relationships for wellness within the ministry community, develop word of mouth

campaigns and elicit connections with local governmental agencies, case managers and cultural outreach activities that is itself funded by governments and philanthropic not for profits to overcome hurdles to signups by restoring and building confidence in a health care system that most believe rejected them. We have to earn the good will from community endorsers to obtain signups beyond that which is direct referral from brick-and- mortar providers with existing provider relationships.

Unlike the other USF funded pilots, the Connected Care pilot broadband service provider is not just hooking up a router and turning a switch on one side of the connection. It will take much more than hiring a Black singer, actor, golfer, a former beauty queen or a hot of color personality of any age and gender to break through the last mile barriers of low income communities. The Connected Care broadband services pilot participants must establish TRUST and prove that patients deserve and can receive respect for their most personal possessions: their time, dignity and their life-- as they age-in-place, recuperate or maintain a chronic condition treatment plan. Not only do we have to be culturally conscious in how we connect with and train the patient, but also involve the family and the caregivers in accessing the new world of technology-driven windows of knowledge that is now at their fingertips and a linguistic voice from outside their neighborhood responding to their wants.

For that reason we believe ultimately what distinguishes the various *silos* of USF programs, initiatives and pilots tested and advanced over the years to carry out the FCC's unquestionably broad authorities and jurisdictions provided by statute, should be fully considered inside the Commission itself as it carves out and sets the boundaries for this still unmet bold initiative that is finally emerging as the technological foundation for the long awaited disruptive transformation of the US health care economy and its failed delivery system infrastructure.

Finally, we thought it also would be helpful at the Comment stage for a potential FCC Connected Care pilot applicant to take steps to initiate the knock-on-the-door approach with health providers and ETCs seeking to create the then FCC NOI inferred preferred Connected Care Initiative pilot "partnering" contract and together preparing a competitive application. We wanted to be armed with that experience at the REPLY stage to present what hurdles we could not know before that might impact upon performance of a comparative competitive pilot application.

Telemedicine Centers USA is confirming the observation issued by PWC that "interest in forming new business models are emerging in an industry that has long resisted significant change, signaling the possibility that profound disruption may occur". The DOJ announced approval by DOJ today of the CVS-Aetna $69B M&A transaction boasting the creation of a nationwide telemedicine services network featuring its 9000 health store sites that will be

augmented by its building freestanding mini-clinic locations to complement its drugstore Minute Clinic operations and to support walk-in doctor office management of chronic conditions and remote monitoring.

In knocking on doors of unusual entities in health care to discuss the FCC Connected Care Pilot, it can't be missed that CVS/Aetna is one of these talked about new models—Vertical Integrators/Health Retailer preparing itself to compete against the Employer Activist model [like JP Morgan Chase, Amazon and Berkshire Hathaway that was followed shortly by Wal-Mart the nation's largest employer, and actions by Ford and General Motors], and the Technology Invaders model [like Teladoc, American Well, etc.]—largely all involve new entrants combining with traditional players to offer consumers more convenient, affordable and effective care while cutting costs and creating value and scale to compete more effectively.

Knocking on doors of private practicing PCPs and specialist providers, to discuss the Connected Care pilot, they are very bothered by the prospect of new CVS company owned doctor offices coming into their neighborhood and offering home direct monitoring and Pharma services. Knocking on doors of hospitals for a similar chat about the Connected Care Pilot, and the competitive prospects from Employer activists setting up its own employee operated clinics and eliminated ER visits, and the reduction from traffic from the Technology Invaders and Urgent Care Clinics, Vertical integrated insurers that can direct insureds to owned Urgent Care and lower cost online resources threatens stability and margins.

Most interesting, those health care participants are not really seeking how to reach low income Americans and Veterans as their targets. In fact, an overlay of where CVS drug stores/ new mini-clinics with doctors for walk-in show and the unserved/underserved live will be negligible in having an impact on health care access and improvement. The FCC Connected Care Pilot initiative promises to be the only viable lifeline to this targeted population.

However, referring back to the information proffered from the 80 or so FCC Comment filers, it certainly appears that applications to undertake a pilot will require entrepreneurial and community organizational talents to negotiate and navigate through the gaping holes that continue to leave millions of the population without meaningful access and affordable health care.

Having the technology and broadband connectivity, when the competition is committed to doubling down on forcing community office-centric services and reliance on costly limited capacity communications on a pay-as-you-go basis will be inferior to what the FCC Connect Care Pilot can leverage. After all, the low income underserved population has enough buying

power collectively to impact each of these new models types and the entrenched providers who are watching their declining market share and margins rethink their lack of action.

Thank you for the opportunity to make this REPLY,

E-Signed WTJ

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